REFUSAL OF IMMUNIZATION
For Medical Reasons

As the physician of:

Child's Last Name First Name Age

Birth Date School Grade

A. I have elected to not immunize this student against the following disease(s): (check box*)

- Diphtheria ☐
- Tetanus ☐
- Pertussis ☐
- Polio ☐
- Measles (Rubeola) ☐
- Mumps ☐
- Rubella (German Measles) ☐
- Hepatitis B ☐
- Varicella (chickenpox) ☐

In my opinion, this/these immunization(s) would be injurious to the health and well-being of

- The student ☐
- A member of the student's household or family ☐

Comments _____

Signature of Physician Date

* Each disease for which a vaccine has not been administered must be checked. Parent / guardian must submit dates of immunization for all other diseases.